

MEDICAL STATEMENT

FOR CHILDREN WITH DISABILITIES REQUIRING SPECIAL NEEDS

IN CHILD NUTRITION PROGRAMS

PART I

Date _____

Child's Name _____ Age _____

School District _____ School _____

PART II (To Be Completed By Physician)

Diagnosis: _____

Describe the child's disability and the major life activity affected by the disability: _____

Does the disability restrict the child's diet? Yes _____ No _____

List dietary restrictions or special diet: _____

List allergies or food intolerances: _____

List foods that require a change in texture: _____

List required special equipment: _____

Date _____ Signature of Physician _____

PART III (Parent/Guardian Signature)

Date _____ Signature of Parent/Guardian _____

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